CONSULTANT'S CORNER

THE PHYSICIAN-PATIENT CONTINUUM

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In this article, a physician attorney introduces a novel paradigm, the Physician-Patient Continuum, and discusses a survey of 50 medical malpractice claims and the Continuum's relationship with communication breakdowns, adverse outcomes and claims.

Data derived from medical malpractice claims can be aggregated and reviewed from a number of perspectives. These include the medical specialty of the provider, the patient's illness, the patient's injury, the legal issues involved, and others. It is my contention that most medical malpractice claims related to diagnosis and treatment, as opposed to those with special allegations, such as a breach of confidentiality,[1] can be juxtaposed at points along a continuum of interaction between physician and patient, the Physician-Patient Continuum. (Figure 1). At these few interactional points, the risk of an adverse patient occurrence, either natural or iatrogenic, is heightened through a physician's act or omission. Moreover, such clinically oriented claims are often catalyzed by breakdowns in communication between physician and patient.

The Physician-Patient Continuum

History and Physical Examination
Education
Diagnostic Procedures or Referrals
Equipment Usage
Follow-up
Education
Therapeutic Procedures or Referrals
Courses of Therapy
Equipment Usage
Follow-up

FIGURE 1

From September 1, 1990 to August 31, 1993, approximately 450 claims were filed against the United States that alleged negligence by Navy health care providers. Payment was made in 40 percent of those claims. Fifty paid closed claims were randomly selected from records maintained at the Navy Bureau of Medicine and Surgery. These claims were then analyzed to determine where, along the Physician-Patient Continuum, an adverse patient occurrence developed.

OBSERVATIONS

Table 1 illustrates the points of interaction between physician and patient where an act or omission presaged a paid claim. In some cases, negligence may not have been evident but a claim was nonetheless settled. Three cases (6 percent) in this study were specifically reported as nuisance settlements. This compares with a recent analysis that found that 45 percent of 713 paid DoD malpractice claims were cases where the medical standard of care was determined by peer reviewers to have been met.[2]

Table 1 demonstrates that 41 of these 50 paid claims occurred at three points in the

INTERACTIONAL POINTS

	Number	Percent
History/Physical	13	26
Dx Procedures/Referrals	12	24
Dx Follow-up	5	10
Tx Procedures/Referrals	16	32
Courses of Therapy	2	4
Tx Follow-up	2	4

TABLE 1

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Physician-Patient Continuum, specifically, history and physical examination (13), diagnostic procedures and referrals (12) and therapeutic procedures or referrals (16).

Problems in communication or education could not be accurately discerned from a record review. A marker suggesting its absence, an allegation that informed consent was not obtained, was, however, present in nearly half the cases.

SPECIALTY

	Number	Percent
Obstetrics/Gynecology	16	32
Family Practice	10	20
Surgery	6	12
Internal Medicine	5	10
Anesthesiology	3	6
Radiology	2	4
Pathology	2	4
Emergency Medicine	2	4
4 Other (1 each)	1	2

TABLE 2

INJURY

	Number	Percent
Perinatal	9	8
Tumors: brain, breast, lung	8	6
Myocardial Infarction	4	8
Ectopic Pregnancy	4	8
Sterility	3	6
Vas Deferens	2	4
20 Other (1 each)	1	2

TABLE 3

The specialties represented are listed in Table 2. Certain specialists, such as internists, may have multiple interactions with patients along the continuum, while pathologists might only have one, e.g., in tissue interpretation. Some cases involved physicians who were in graduate medical education and under staff supervision.

Culpability was occasionally assignable to more than one provider. In these cases, the earliest physician-patient interaction was counted, unless an allegation of lack of informed consent stemmed from the first interaction. Thus, where an ulnar nerve is injured during anesthesia and a lack of informed consent as to that complication is asserted against the surgeon, a problem regarding a therapeutic procedure was deemed to have occurred.
Patient injury, natural or iatrogenic, spanned the spectrum depicted in Table 3 (above).

Regarding specific claims, one involved a delay in diagnosing a brain tumor from an inadequate history and physical examination for a headache. Another was filed after a patient sustained a nasal injury when potassium hydroxide solution, not saline drops, was inadvertently given. Other cases involved multiple allegations, such as when a complication of a diagnostic procedure occurred in concert with an inadequate history and examination.

There are other noteworthy observations regarding these cases.

—Three of the Family Practice claims concerned obstetric management.

—One claim, involving an internist standing emergency room watch, resulted from a misdiagnosis of gastroenteritis in an infant subsequently found to be a manifestation of diabetes mellitus.

—A similar claim, involving an orthopedist in the emergency room, was prompted by a misdiagnosis of adult gastroenteritis later determined to be a partial bowel obstruction.

—Another claim, concerning a failure to treat luteal phase, inadequacy was due, in part, to the absence of a summary problem list.

DISCUSSION

As catalysts for claims, the importance of communication problems is widely recognized, surpassing both the severity of the injury or monetary costs involved.[3] In a study by Shapiro, *et al.*, two-thirds of patients and physicians who had been embroiled in malpractice litigation felt that the key to reduced litigation was better communication.[4]

From the patient's perspective, five factors determine the adequacy of communication:

1) the comprehensiveness of the initial and periodic history and physical examination;
2) the time the physician spends in education with respect to diagnosis, contemplated procedures and courses of therapy;
3) the time the physician spends in ascertaining the patient's understanding and acceptance of diagnostic and treatment plans;
4) the courtesy of other staff providers; and
5) follow-up endeavors.

In claims where the lack of informed consent is alleged, its corollary, a claim of lack of education, may be inferred. While informed consent as a legal issue is usually secondary to a treatment error, the source of informed consent claims is most often poor physician-patient communication. From one court's perspective, the physician as educator is symbolized by his role as the "learned intermediary" in the context of prescription drugs:

> Prescription drugs are likely to be complex medicines, esoteric in formula and varied in effect. As a medical expert, the prescribing physician can take into account the propensities of the drug as well as the susceptibilities of his patient. His is the task of weighing the benefits of any medication against its potential dangers. The choice he makes is an informed one, an individualized medical judgment bottomed on a knowledge of patient and palliative. Pharmaceutical companies then, who must warn ultimate purchasers of dangers inherent in patent drugs sold over the counter, in selling prescription drugs are required to warn only the prescribing physician who acts as a "learned intermediary" between manufacturer and consumer.[5]

Medical follow-up has many facets and is often a dual responsibility of both physician and patient. The physician may advise the patient to seek consultation or return after a test is completed. The patient may or may not comply. While relative culpabilities will be apportioned at the time of settlement or judgment if claimant prevails, it was recently observed in this publication that "the attending provider who orders a diagnostic study warrants its clinical necessity and obliges himself to pursue its result."[6]

CONCLUSION

Efforts should be focused on improving communication, particularly at those points in the Physician-Patient Continuum where claims often arise. For example:

— Is descriptive literature regarding procedures and drugs reviewed with the patient and is that review documented in the medical record?

— For urgent or emergency consultations, are physician to physician referrals made or are they accomplished through ancillary staff?

—Is the hospitalized, surgical patient advised who will participate in performing a procedure and who will share in providing postoperative care?

By attention to these and similar issues, the number of meritorious claims might be reduced.

Adequate physician-patient communications admittedly require time and, as one commentator has noted, compulsiveness.[7] Problems in education or other communication difficulties can imply insufficient time spent with patients. In court, the notion that a physician did not have enough time to spend with a patient never creates a favorable impression.

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